Medicare Payment Advisory Commission, April 2026 Public Meeting
April 9-10, 2026
[Meeting materials available on the MedPAC website here.]
Meeting Summary

On April 9-10, 2026, the Medicare Payment Advisory Commission (MedPAC, or "the Commission") held its April public meeting. HFMA presents a summary of that meeting. Unless specifically attributed to MedPAC commissioners or staff, all forward-looking statements in this summary reflect a prognostication of the Commission's likely actions; such statements are not informed by any proprietary or inside information about MedPAC's future plans.

Thursday, April 9, 2026

1. IMPROVING PAYMENT INCENTIVES IN MEDICARE (Rachel Burton, Luis Serna, Stuart Hammond; 10:45 AM – 12:10 PM)

ISSUE: Medicare spending is projected to nearly double over the next decade, driven by expected growth in the number of beneficiaries and in the volume and intensity of services delivered per beneficiary. Since payment policy can have an impact on volume and intensity growth, it is important to consider the advantages and disadvantages of Medicare's different payment methods - fee-for-service (FFS), alternative payment models (APMs) such as accountable care organizations, and Medicare Advantage (MA) - and improvements that should be made to each.

PRESENTATION: This session revisits the topic first presented at MedPAC's December 2025 public meeting. The presentation is very similar to the December 2025 presentation, with minor changes reflecting commissioners' discussion at that meeting. The material summarizes a draft informational chapter that will be published in the Commission's forthcoming June Report to the Congress.

The staff presentation recaps MedPAC's three principles for payment policy, and provides an overview of the three main payment mechanisms used by Medicare – FFS, APMs, and MA. The presentation gave an overview of the drivers of Medicare spending in the next 10 years, with the largest driver anticipated to be growth in volume and intensity of services, and growth in prices of drugs covered under Medicare Part B. Staff compared changes in Medicare Part A spending (-2.2%) and Part B spending (+19%) over the last 10 years.

Staff then gave a short overview of the incentives intrinsic to each of Medicare's main payment models (staff continue to assert that FFS has an incentive to increase volume of services, especially in the case of overpriced services). Staff noted the program's ongoing difficulties setting FFS prices accurately, and that FFS pricing is particularly challenging for new technologies. Interestingly, staff noted that APMs face the same incentive to aggressively code

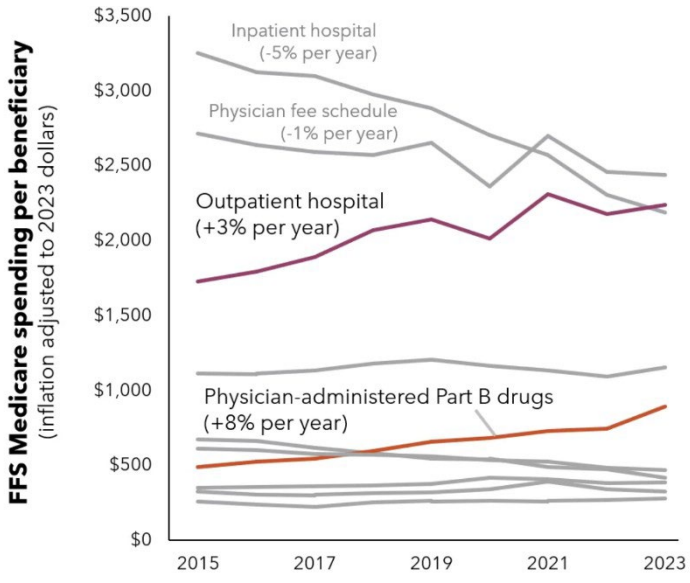
their assigned patients as MA plans. Lastly, staff recapped myriad issues with MA payment policy that have precluded the MA program from saving money relative to traditional FFS.

The staff presentation then reviewed some of the Commission's key recommendations relevant to each of the three payment models. For example, in FFS, staff cited its annual payment update recommendations, and its recommendations for site-neutral payments; under APMs, staff cited to its recommendation to remove payment "ratchets;" under MA, staff pointed to the Commission's recommendations to reduce coding intensity, and to overhaul the MA Quality Bonus Program.

DISCUSSION: Commissioners asked a few round one clarifying questions. Commissioner Greg Poulsen asked about the potential to further break out the effects of spending on drugs from other Part B spending, arguing that these increases should not be lumped together with "volume and intensity."

Commissioner Thomas Diller led the round two discussion commenting on slide 8, which shows the growth in health care spending between 1975 and 2025. He noted the effect of HMOs on health care spending in the 1990s, and the effect of the Affordable Care Act in the 2010s – during both of these periods, health care spending flattened. He argued that these periods indicate that "FFS doesn't work." He asserted that APMs are fundamentally flawed because they are simply overlaid on FFS. He argued that narrow networks with accountability for cost and quality are most likely to achieve success in controlling health care spending. Commissioner Brian Miller echoed many of Commissioner Diller's comments, also asserting that FFS does not work, and suggested importing some MA care management tools into FFS. He critiqued the "micro-targeting of price" in FFS, and asserted that CMS's role would best be shifted away from price-setting and more toward a "regulatory" role. For example, CMS should focus on major benefit design issues – such as a preferred-provider organization approach to FFS.

Commissioner Tamara Konetzka suggested staff include a table in the draft chapter that would compare FFS, APMs, and MA on various axes (*e.g.*, efficiency, quality, access, *et cetera*). She supports the Commission's further work on improving MA so that Medicare can "reap the benefits" of capitation. Commissioner Paulsen expressed general kudos for the draft chapter. He repeated his round one comments on the effect of growth in prices for Part B drugs on Medicare spending (focused on slide 16 of the presentation, excerpted to the left).



Commissioner Poulsen also asserted that the chapter gives short shrift to the demographic impact of aging (especially the baby boomer generation) on future Medicare spending. Lastly, he stressed the urgent need for MA reforms given the growth in that component of the Medicare program, stressing the need to

address favorable selection and coding intensity. He noted that 1/3 of MA plans actually cost *less* than FFS, even in providing supplemental benefits. Strikingly, *he urged that the current MA risk adjustment system be completely eliminated*. He argued it should be replaced with a process of setting benchmarks based on past spending, and trending them forward.

Commissioner Robert Cherry also praised the chapter. He suggested that the chapter, in addition to focusing on incentives under the three payment models, also devote some attention to the *disincentives* of each model. Commissioner Stacie Dusetzina asserted that despite the problems with FFS, the traditional FFS program needs to be improved as a matter of beneficiary choice, and also because of its foundational role in APMs and MA (*e.g.*, FFS-based MA benchmarks). She believes that MedPAC should revisit its prior recommendation for a cap on beneficiary out-of-pocket (OOP) spending, and should analyze ways of steering beneficiaries to high-value care. Commissioner Cheryl Damberg suggested that future analyses of these payment models emphasize "value" to the Medicare program. Commissioner Paul Casale agreed with many of the other commissioners' comments. Vice Chair Betty Rambur agreed that the Commission should revisit its 2012 recommendation for an OOP cap on beneficiary cost liability in FFS. Interestingly she cast low-value care as "not only an economic, but also an ethical issue."

Other commissioners generally supported the tone and direction of the draft chapter, and made various suggestions for the inclusion of specific points of information, or emphasizing certain conceptual points. Chair Chernew summarized the commissioners' discussion as: 1) strongly critiquing FFS Medicare (but still needing to improve it), 2) emphasizing the role of beneficiary choice, especially with respect to Medicare Advantage, 3) emphasizing the role of Part B drugs under FFS (by contrast to the other commissioners, he asserted that Part B drug prices *are* a function of volume and intensity; he also stressed the value of pharmaceutical innovation).

2. MANDATED REPORT: ASSESSMENT OF THE MEDICARE GROUND AMBULANCE DATA COLLECTION SYSTEM (Dan Zabinski; 12:15 PM - 12:45 PM)

ISSUE: The Bipartisan Budget Act of 2018 directs the Commission to assess the information submitted by ground ambulance service providers under a recently implemented data collection effort, including the burden on ambulance organizations of collecting the data. The mandated report is due June 15, 2026. The Commission must provide a recommendation to the Congress as to whether CMS should continue to collect these data and whether the data collection system should be revised. Staff presented on this topic at the March MedPAC public meeting, and commissioners discussed a draft recommendation from the Chair at that time.

PRESENTATION: The staff presentation provided a very high-level recap of the March 2026 meeting material and material presented over several prior sessions. The recap included the ground ambulance data collection requirements under the BBA, 2018 (including the Commission's mandated report on such data collection), the Commission's assessment of CMS's data collection system, and the usability of the information collected to date (see the Commission's March 2026 meeting material here).

Staff then provided an overview of the Medicare Ground Ambulance Data Collection System (GADCS). The data collection system includes data on ambulance organizations' characteristics; service area, volume, and mix; staffing; costs; and revenues. Of the 10,600 ambulance organizations surveyed that provided services in 2017, 2018, or 2020: about 1,350 did not submit data as required (and received a 10 percent payment reduction per statute for one year); about 1,650 were dropped because they were no longer active; and about 7,500 submitted data for 2022 or 2023. Staff noted that the GADCS collects over 600 separate data variables, and indicated that this is probably more than necessary for the purposes of the statute – MedPAC noted that staff only used about 150 of these variables in their assessment of the integrity of the data.

Staff suggested that the GADCS could be streamlined by collecting fewer data elements, and by collecting these data from reporting entities less frequently than annually.

Interestingly, staff spent a considerable amount of time recapping the substantive results of their prior analysis of GADCS data, above and beyond whether the data collected are sufficient to discharge CMS's statutory mandate. They found that the number of transports has a strong effect on an organizations' costs, with organizations in the highest quartile of transports having the lowest cost per transport ($914) and those in the lowest quartile of transports having the highest cost per transport ($2,852). Type of ownership (for profit, nonprofit, governmental) also was associated with costs, with for-profit organizations having lower costs per transport ($575) than nonprofit ($849) and government organizations ($1,675). Staff noted that service area location (urban, rural, super rural) did not have a significant effect on cost per transport. Staff then discussed how various factors may contribute to the observed differences in costs. For example, lower costs of for-profit organizations could be attributable to a number of factors, including that they may have more transports, a different staffing model, or a less complex service mix. Staff performed a regression analysis to isolate the effect of each cost driver while holding other factors constant. The regression analysis showed that (i) the number of transports and (ii) location of the organization stood out as correlating with cost. The results showed economies of scale. Smaller organizations, according to this analysis, will have higher costs than larger ones. This finding is notable because the ambulance services fee schedule currently does not have a payment adjustment for low-volume organizations.

Staff discussed the revenue-to-cost ratio. Staff expressed concerns about the revenue data and cautioned about how it is used. For example, the data MedPAC used in its analyses represented the first year that organizations submitted revenue data, and some organizations have large differences between revenue and costs. Preliminary results showed that government organizations have lower ratios than for profit and nonprofit ambulance organizations. If government organizations are removed, staff found that revenue-to-cost ratios increase as a function of the number of transports.

Staff then reviewed the structure and components of the GADCS. The GADCS includes cost data that can be used to assess the accuracy of ambulance service fee schedule payments and includes sampling weights so that nationally represented results can be obtained.

In summary, staff found that the GADCS is a good first step to evaluate accuracy across patient severity levels and geographic locations, and that data collection should continue but can be streamlined.

The draft recommendation that was presented for the Commission vote is:

- The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services.
    - Data collection should focus on information essential to assessing both the accuracy of Medicare payments and Medicare beneficiaries' access to care; and
    - The Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers.

(Note that this language was unchanged from the draft recommendation discussed in March 2026.)

The recommendation has no spending implications, or implications for beneficiaries' access to care or providers' willingness to provide that care.

DISCUSSION: Commissioner Miller praised the staff work; he noted that while there are economies of scale under the ambulance fee schedule (AFS), the Medicare program does not benefit from those economies of scale. He noted, however, as a first principle, that Medicare should be considering competitive models for setting prices under the AFS, not cost-based payment approaches. Commissioner Diller raised the question of whether Medicare should pay differently for the different delivery models for ambulance services.

The Commission's vote was almost unanimous in favor of the recommendation among commissioners present; Commissioner Miller abstained, and Commissioners Lynn Barr and Kenny Kan were not present for the vote.

3. ANALYSIS OF REGIONAL BENCHMARKS AND BENCHMARK-PLAN AVAILABILITY IN THE PART D PRESCRIPTION DRUG PLAN (PDP) MARKET; (Tara Hayes and Shinobu Suzuki; 2:00 PM - 3:00 PM)

ISSUE: In the June 2025 report to the Congress, the Commission discussed trends in Part D that could affect the long-term stability of the stand-alone prescription drug plan (PDP) market. The number of benchmark PDPs, which are available at no premium to beneficiaries who receive Part D's low-income subsidy, has been declining. In 2025, there were four regions with just a single benchmark plan. Commissioners were asked to review and discuss information on the mechanisms that determine which plans qualify as benchmark plans and how those mechanisms affect the number of benchmark plans in a region. This is a standalone presentation, and will not appear in MedPAC's published reports this cycle.

PRESENTATION: MedPAC's June 2025 raised a number of concerns about the standalone PDP market. This presentation detailed information surrounding one of those concerns, specifically, the reduction in the number of PDPs available to beneficiaries in FFS Medicare.

Staff began the presentation with a technical discussion of how Medicare Part D subsidizes low-premium plans (known as benchmark plans, which are plans with premiums below the average in their markets), focusing on the interaction between PDPs and Medicare Advantage Prescription Drug Plans (MA-PDs). As MA-PDs have grown in popularity, the number of benchmark PDPs has declined. Sponsorship of PDPs has become more concentrated over time, with one insurer accounting for nearly 60% of PDP enrollment in 2025. Staff discussed Medicare's programmatic safeguards (such as fallback plans) designed to ensure access to prescription drugs in light of these changes, but still noted the importance of beneficiary choice in ensuring a robust Part D market.

Staff described three factors affecting the availability of PDPs in any given region: the raw number of PDPs available in a region, low-income subsidy (LIS) plan enrollment distribution, and premiums for basic benefits among PDPs and MA-PDs, the latter factor being the most important in explaining the availability of PDPs. Specifically, when MA-PD premiums are lower than PDP premiums, the number of benchmark PDPs will be lower. Staff report that this phenomenon is a direct result of the formula Medicare uses to calculate PDP benchmarks.

Staff then discussed factors that affect Part D premiums, noting that MA-PDs had lower risk-adjusted costs than PDPs, but MA-PDs had higher risk scores due to coding intensity.

Staff mentioned that the PDP Premium Stabilization Demonstration has been in effect in 2025 and 2026.

DISCUSSION: Commissioner Gina Upchurch in round one asked a number of questions, including if enhanced MA-PDs benefited from manufacturer rebates. She asked if plans are trying to avoid sicker, more expensive low-income patients, and if so, would this contribute the decline in the number of benchmark PDPs.

Commissioner Upchurch led the round two discussion. She asked, "who contributes to the Part D plan and how much are they paying?" (Note – question was unclear, but in subsequent discussion she parsed the question asking how much of Part D costs are covered by Medicare beneficiary premiums, drug manufacturers, the Medicare program (direct subsidies), states, and plans.) She discussed "under-enrollment" in the Part D low-income subsidy, asserting that 1/3 of beneficiaries eligible for the subsidy are not actually enrolled. Commissioner Miller appreciated the meeting materials, and agreed that Medicare needs a robust, functioning standalone PDP market. He noted, however, that PDPs do not have the tools to mitigate or shift costs that are available to MA-PDs. He asserted that Part D has been "broken" by pharmaceutical pricing, and raised a couple of provocative policy considerations (*e.g.*, move current Part B drugs to Part D, or expand community pharmacy by allowing community pharmacists to form Part D plans).

Commissioner Dusetzina asked questions related to Part D market segmentation, focusing on the role of MA special needs plans (SNPs) (SNP premiums and their LIS counts are included in the

calculation of Part D benchmarks). (Like Commissioner Upchurch, given her interests and expertise in pharmaceuticals, Commissioner Dusetzina's questions were extensive, and somewhat technical.)

Commissioner Kan pointed out a disconnect in the Part D benefit, arguing that PDPs and MA-PDs should be treated separately with respect to benchmark calculations, risk adjustment, *et cetera*). Chair Chernew stated that he saw the appeal of such an approach, but noted that it may be extremely difficult to execute. He encouraged staff to continue this work in the next analytic cycle, noting the importance of a functioning PDP market for beneficiaries who choose traditional FFS Medicare.

4. PREFERRED NETWORKS AND PHARMACY ACCESS IN PART D (Renuka Diwan and Shinobu Suzuki; 3:05 PM - 4:05 PM)

ISSUE: Pharmacy access for Medicare beneficiaries depends not only on the presence of local pharmacies but also on how Part D plans contract with them. Part D plans establish a set of in-network pharmacies where beneficiaries can use their insurance, and plans may designate some pharmacies as preferred, typically with lower cost sharing. Commissioners were asked to review and discuss findings from an initial analysis of beneficiary access to pharmacies in stand-alone PDPs. Like the previous session, this material will not be published in a MedPAC written report this cycle.

PRESENTATION: Staff provided an overview of Medicare's Part D pharmacy network adequacy requirements, differentiating between preferred and non-preferred pharmacies. Staff then recounted the decline in retail pharmacies which potentially affects beneficiary access to medications under Part D. This trend has been particularly acute in rural areas. The decline has accelerated over the last two years. Chain pharmacies account for 60 percent of pharmacies in urban areas, but only 35 percent in rural areas.

Staff attempted to measure beneficiary access to pharmacies using ZIP codes or counties, and noted that either measure may overstate access problems, because beneficiaries can easily travel to another ZIP code to find a pharmacy. That said, the share of beneficiaries residing in areas without pharmacies has increased over time, a pattern which held across all levels of geography. Nevertheless, staff indicated that most Part D enrollees do have access to a pharmacy in their area, or an adjacent area.

Staff then discussed issues related to "preferred" pharmacies, examining the PDP market (due to the complexity of defining markets served by MA-PDs). Staff found that Part D networks cover about 90 percent of the pharmacies in their regions, with networks modestly favoring chain pharmacies. "Preferred" pharmacies may offer lower cost sharing to attract use. In 2025, about 44 percent of in-network pharmacies were designated as "preferred," with chain pharmacies disproportionately designated as such. About 30 percent of PDP enrollees live in ZIP codes with no preferred pharmacy, but about 60 percent of rural beneficiaries live in such ZIP codes. The difference was reduced when access was assessed at the county level, but still persist, with 36% of rural beneficiaries living in a county without a preferred pharmacy in 2024.

Staff discussed "network churn," the entry and exit of pharmacies from plan networks. Pharmacy exits were driven more by pharmacy closures than contract changes between 2022 and 2024.

Again, this session is informational, and not slated for publication at this time, but staff plan to continue this work over MedPAC's next analytic cycle.

DISCUSSION: Commissioner Poulsen asked how chain pharmacies are defined in round one, asking in particular how pharmacies located in grocery stores are defined. He also asked whether the decline in pharmacies is related to the increase (and subsequent failure) of pharmacies that attempted to become primary care sites over the last decade or so. Commissioner Konetzka asked about beneficiary implications of the distinction between preferred and non-preferred pharmacies. Commissioner Damberg asked a similar question about differences in OOP costs between beneficiaries with, and without, access to preferred pharmacies. Other commissioners asked minor clarifying questions about the material.

Commissioner Dusetzina led the round two questions with further questions about the distinctions between preferred and non-preferred pharmacies, noting that often non-preferred pharmacies do not offer the lowest cost sharing for the Part D enrollee. Similarly, mail-order pharmacies do not always offer the lowest price.

Commissioner Miller stated that MedPAC should not be making recommendations based on anecdotes about prices from plan finder, *et cetera* (seemingly rebutting Commissioner Dusetzina). He commented on certain data elements touched on in the mailing materials, but it was difficult to connect the various points that he mentioned. However, he seems to have concluded that chain pharmacies are experiencing difficulty and contributing to network churn (pointing to Rite Aid), whereas independent pharmacies are maintaining stability (by contrast to the general thrust of the staff presentation).

Commissioner Damberg asked if pharmacy closures were disproportionately in low-SES areas of the country. She also asked if MedPAC's beneficiary survey asks questions about pharmacy access. Commissioner Upchurch raised the issue of "appropriate use of medications," devaluing the clinical expertise of pharmacists by tying reimbursement to volume of prescriptions dispensed. She made extensive comments about the relationships between pharmacy benefit managers, plans, and pharmaceutical manufacturers that work against the interests of independent pharmacists and beneficiaries. She was demonstrably passionate in her commentary, but the direction to staff in terms of future Commission work was unclear. She asserted that many of the problems facing the Part D benefit stem from not treating pharmacists as clinical team professionals, and not paying them for the services they provide.

Commissioner Kan expressed concerns about the decline in the number of pharmacies and implications for beneficiary access.

5. ESTIMATED ASSOCIATION BETWEEN MEDICARE ADVANTAGE ENROLLMENT AND HOSPITALS' AND POST-ACUTE CARE PROVIDERS' FINANCES (Brian O'Donnell, Betty Fout, Krista Cherry, Alison Binkowski, and Carol Carter; 4:10 PM - 5:30 PM)

ISSUE: Medicare Advantage (MA) has been growing rapidly and now covers more than half of eligible beneficiaries. As a result, MA enrollees now comprise a substantial share of many providers' patients and revenues. Some provider groups have stated that MA growth has been challenging for them, operationally and financially. However, there is limited data quantifying how MA growth has affected the finances of hospitals and post-acute care (PAC) providers. This work follows up on an initial presentation of related material in September of 2025. The combined work will appear as an informational chapter in the Commission's forthcoming June 2026 Report to the Congress.

PRESENTATION: The staff presentation began with an overview of MA enrollment and plan incentives, particularly focusing on plans' incentive to reduce medical spending (*e.g.*, through patient volume, revenues per patient, and cost per patient).

Staff described their earlier analysis examining the association between MA enrollment and hospitals' finances (all-payer revenues, margins, and costs). They described tensions between MA plans and hospitals, with both parties expressing frustration with the other. Staff found that MA beneficiaries typically had longer lengths of hospital stays than beneficiaries in FFS Medicare, with the differences particularly pronounced for beneficiaries requiring post-acute care after hospital discharge. This phenomenon puts substantial financial pressure on hospitals, given that the longer length of stay is not matched by an increase in the plan's payment of the hospital stay. Staff report that MA plans avoid including hospitals with high rates of uncompensated care in their networks.

Staff described the limited health services research on the relationship between MA enrollment and hospital finances, and then recapped the Commission's own research presented in September of last year. Staff continue to assert that a correlation analysis shows there is "no clear relationship" between MA penetration and IPPS hospitals' all-payer operating margin. Staff then conducted a regression analysis, *but interestingly, now characterized the results of their analysis as "associations," rather than causal effects*. Staff emphasized the limitations of this analysis, noting that there were many possible factors that could not be controlled for in the analysis. The results reflect the effects of MA "and other factors." That said, staff continue to assert that there is no statistically significant association between MA penetration and hospitals' all-payer operating margins, revenues, and costs. MedPAC staff also analyzed this relationship stratified by different hospital sub-groups (*e.g.*, size, system affiliation, critical access hospital status, *et cetera).*

Staff presented new analytic work in this session, examining the relationship between MA penetration and post-acute care (PAC) providers' finances. Staff asserted that this relationship may be more pronounced than they observed for hospitals, given the disproportionate share of PAC utilization attributable to Medicare. Staff used a similar regression framework to assess the relationship between MA penetration and PAC providers' finances. Their analysis was limited

to free-standing providers, and thus excluded inpatient rehabilitation facilities (IRFs) from the regression analysis due to the large share of that provider type that is hospital-based.

Staff found small, generally statistically insignificant declines in SNFs' finances as a function of greater MA penetration, and a small decrease in facility days. They also found a similar small, statistically insignificant decline in home health agency all-payer margins as a function of MA penetration, but larger (and statistically significant) declines in provider revenues and costs. Staff reported that MA enrollees' share of IRF days was substantially lower than overall MA penetration between 2013 and 2024. Again, staff heavily caveated this analysis emphasizing that the findings presented reflect associations, not causal factors.

DISCUSSION: Commissioners asked a variety of round one clarifying questions on the staff presentation.

Commissioner Konetzka led the round two discussion, noting that many of her comments were aimed at longer-term work rather than things that could be incorporated into the draft chapter before publication in June (interestingly, she noted that staff may have overly-heavily caveated their analyses). She commented that while staff excluded IRFs from the regression analysis because only one-third of IRFs are free-standing, most of the patients, and most of the growth in use in the IRF sector is attributable to free-standing IRFs, so they should be included in future regression analyses. She observed that while staff did not find striking relationships between MA penetration and providers' finances, the larger story may be the heterogeneity of the findings. (Her comments on this session were extensive.) She concluded that the policy implications of the work are not yet clear.

Commissioner Poulsen agreed with Commissioner Konetzka regarding the importance of the heterogeneity of the findings, and that this work should be treated as an initial step. His other comments on the session were extensive, but here again, the staff direction was unclear; in general, his comments emphasized that the heterogeneity of MA plans and providers makes it difficult to establish clear relationships of the kind the MedPAC staff hoped to test.

Commissioner Miller compared hospitals and MA plans to children fighting at the dinner table, with both parties "behaving poorly." He asserted that hospitals and plans need to "behave" and work better together, citing the discharge process as a primary example of where coordination can be improved. Commissioner Scott Sarran also emphasized the heterogeneity issue, noting that heterogeneity of "market clout" (within markets) is also a confounding factor. He concurred with Commissioner Miller regarding hospitals and MA plans working together to improve processes.

Commissioner Cherry described the work as a "fun chapter" due to the conflicting perspectives reported between plans and hospitals. He commented that consolidation may lead plans to more aggressively employ utilization management techniques. Commissioner Damberg suggested additional work on the relationship between MA penetration (and the purported cost pressures associated with that penetration) and providers' nurse staffing. She supports the idea of changing provider cost reports to calculate MA-specific margins.

Commissioner Kan made a number of comments highlighting the findings that MedPAC found no relationship between MA penetration and providers' finances, and commented that MA is providing better care for beneficiaries. He did, however, acknowledge providers' concerns about utilization management and the administrative burden such techniques impose.

Friday, April 10, 2026

6. INFORMATION SOURCES THAT BENEFICIARIES USE TO MAKE MEDICARE ENROLLMENT DECISIONS (Ledia Tabor, Jennifer Druckman, Pamina Mejia, and Eric Rollins; 9:45 AM - 11:10 AM)

ISSUE: Once an individual becomes eligible for Medicare and during certain times of the year or in specified situations, they must make several complex decisions about their coverage. Beneficiaries often report confusion about enrolling in Medicare and their different coverage options.

PRESENTATION: This session follows up a March meeting presentation on the complexity of enrollment decisions facing new Medicare beneficiaries. The April meeting material will be combined with the March content to compose an informational chapter in the Commission's forthcoming June Report to the Congress.

Staff began this session by briefly recapping the content of the March meeting session on enrollment decisions. They then reviewed prior health services research literature on the sources of information that beneficiaries use to inform those decisions. MedPAC staff convened focus groups to gather firsthand anecdotes about beneficiaries' enrollment decisions and their information sources. Focus groups reported being "flooded" with TV advertisements, many related to Medicare Advantage (MA) plans. Staff described the role of third-party marketing organizations (TPMOs) and Field Marketing Organizations (FMOs) in such ad campaigns.

Staff shifted to describe Medicare's official sources of information: the 1-800-MEDICARE helpline, and the Medicare.gov website, which includes the Medicare Plan Finder. Staff discussed the Plan Finder in some detail, noting recent improvements to the website, but also discussing continued deficiencies (*e.g.*, premiums, supplemental benefits, and provider directories).

Staff described the State Health Insurance Assistance Program (SHIP), under which Medicare provides grants to the states to fund training of counselors (n>10,000) that assist beneficiaries on a one-on-one basis regarding their enrollment decisions. Staff noted that discretionary SHIP funding has declined since 2008 (-26 percent), even as Medicare enrollment has continued to grow (+53 percent). This funding mis-match has constrained SHIPs' capacity to provide counseling appointments for Medicare beneficiaries. Staff conducted interviews with SHIP grantees to provide commissioners with more detail about their functions and operations.

Lastly, staff described the role of insurance agents in assisting beneficiaries with their enrollment decisions. One-third of beneficiaries report working with agents, and report positive experiences in doing so. Staff described how agents market plans to enrollees, and how compensation is structured (subject to some Medicare limitations, such as "fair market value" for initial enrollment commissions). Staff also described the role of agents viz Medigap, which is predominantly regulated by states, rather than the Federal government. Lastly, staff discussed potential financial incentives that agents may have to enroll beneficiaries in certain types of plans

relative to others (*e.g.*, favoring an MA-PD over FFS plus Medigap, or FFS plus a standalone PDP).

DISCUSSION: Commissioner Upchurch asked a variety of round one clarifying questions.

Commissioner Gokhan Metan led the round two discussion with commentary about the growing need for beneficiaries to receive personalized guidance, and the fact that as public funding for SHIPs has declined, this need is being filled by commercial organizations with a vested interest in beneficiaries' decisions. He pointed to the increase in MA disenrollment percentages as a sign that beneficiaries are being steered to plans that are not optimal for them. He stated that SHIP funding shortfalls are a serious problem, as are the deficiencies with Medicare Plan Finder. He recommended restructuring SHIP funding to match Medicare enrollment growth (he suggested that every dollar that MA plans pay for insurance brokers should be matched by a dollar they would be required to pay for SHIPs). He next recommended changing the compensation structure for insurance agents, adding new limits and creating new transparency requirements. Lastly, he discussed the implications of artificial intelligence (AI) for enhancing the Medicare Plan Finder, and spoke favorably of its potential use. It was clear he has given this issue a considerable amount of thought, and feels passionately about assisting beneficiaries with these extremely complex decisions; he may be a thought leader on these issues if the Commission continues this body of work in its next analytic cycle.

Commissioner Dusetzina echoed many of Commissioner Metan's comments. She indicated that the focus groups' accounts of TV ads resonated with her. She agreed that Plan Finder needs further improvements (*e.g.*, adding Medigap information). Interestingly she was more cautious about the use of AI compared to Commissioner Metan. She agreed with the need to change the compensation structure for brokers, and greater transparency in compensation arrangements. Commissioner Damberg agreed with other commissioners regarding the need for SHIP funding to keep pace with Medicare enrollment.

Commissioner Upchurch also spoke on this topic, informed by her experience running a SHIP program in North Carolina. She spoke extensively, and in great detail, about problems with Medicare Plan Finder, noting that her organization has been asking CMS for improvements to Plan Finder "for years," without tangible results. Commissioner Upchurch commented for 15-20 minutes, and much of her commentary consisted of recitation of existing (and real) problems, but the direction to staff regarding policy or operational fixes was unclear. (She emphasized the implications of timing of Part B election, noting that late enrollment is a problem, but also that enrolling in Part B too early has permanent negative implications for subsequent access to Medigap plans.)

Commissioner Konetzka stated that a commission-based broker system is fundamentally flawed, and cannot result in decisions that are in beneficiaries' best interest due to financial bias. She asserted that Medicare needs to "crack down on misleading advertisements." She stressed the need to simplify the choices facing Medicare beneficiaries. Commissioner Miller echoed Commissioner Metan's comments regarding improvements to Plan Finder using AI; he disagreed with other commissioners regarding the need to regulate commissions, and instead argued for "market-based" solutions. Regarding misleading TV ads, he noted that CMS approves all such

MA marketing materials, so if there are problems with the ads, we should "blame" CMS. He noted that beneficiaries engage in myriad financial transactions where the participants have financial interests, without the need for excessive government regulations ("the federal government doesn't mandate that Ford sell Hyundais"). He noted that beneficiary choices based on personal values often don't result in optimal choices (*e.g.*, choosing to buy a convertible rather than an SUV; "we do not have counselors telling us who to marry or who to be friends with"). Commissioner Kan used the opportunity to comment to promote Medicare Advantage. Commissioner Sarran agreed with Commissioner Metan's comments on the potential for AI-enabled tools to assist beneficiaries with enrollment decisions. ("Plans have been horribly underregulated with respect to accurate provider directory information.") He also agreed that there is a pressing need to revise the compensation model for insurance brokers. Commissioner Cherry praised the draft chapter, and agreed with many of the points raised by other commissioners (*e.g.*, need to add resources to SHIPs).

As noted above, this material will be combined with the March meeting material to compose an informational chapter in the Commission's June 2026 Report to the Congress. Given the level of commissioner interest in the topic, the Commission is expected to continue to pursue this body of work in its next analytic cycle, potentially working towards recommendations on: 1) increasing funding for SHIPs, 2) improvements to Medicare Plan Finder, and 3) changes to insurance broker compensation structures.

7. INSTITUTIONAL SPECIAL NEEDS PLANS: PROVISION OF SERVICES, NETWORK ADEQUACY REQUIREMENTS, AND STAR RATINGS (Eric Rollins; 11:15 AM - 12:15 PM)

ISSUE: In 2022, about 1.2 million beneficiaries lived in nursing homes (NHs), which provide services such as 24-hour medical and skilled nursing care, rehabilitation services, meals, and assistance with activities of daily living. As a group, the long-stay NH population has significant care needs and high medical costs, and there have been long-standing concerns about the quality of care they receive in NHs. About 12 percent of long-stay NH residents are enrolled in institutional special needs plans (I–SNPs), which are specialized Medicare Advantage plans for beneficiaries who live in NHs. These plans aim to improve quality and manage costs by providing more care in the NH setting and modifying how NHs are reimbursed.

PRESENTATION: The Commission previously discussed I-SNPs in its June 2025 Report to the Congress. The material presented here builds on that chapter. This material will not be published this cycle, but if there is sufficient commissioner interest, it could be developed during the Commission's next analytic cycle and published as an informational chapter in MedPAC's June 2027 Report to the Congress.

The staff presentation provided basic information on the prevalence and availability of I-SNPs, noting that prevalence of I-SNPs is low, and enrollment in I-SNPs is low even where the opportunity to enroll exists. Only about 12 percent of institutionalized Medicare beneficiaries are enrolled in I-SNPs. Staff indicated that little is known about the I-SNP model of care. Staff briefly reviewed utilization of evaluation and management (E&M) visits by I-SNP enrollees

compared to other beneficiaries, and noted that I-SNP enrollees receive more E&M visits, and that these visits are frequently provided by nurse practitioners.

Next, staff described a mismatch between Medicare's MA network adequacy requirements and the I-SNP model of care, noting that I-SNP enrollees typically get the majority of their health care in the institution in which they reside. Staff discussed some policy options that the Commission could pursue to address this mis-match (at the extreme, allowing I-SNPs to operate without a provider network). Staff also noted that the MA star ratings system is also ill-suited to I-SNPs, while at the same time reporting that most I-SNPs do receive quality bonus payments. With respect to network adequacy, staff raised several options that the Commission could pursue to tailor the Quality Bonus Program to I-SNPs (*e.g.*, a completely distinct star ratings system for I-SNPs) and discussed the pros and cons of these options.

DISCUSSION: Commissioners asked several round one clarifying questions.

Commissioner Sarran led the round two questions, suggesting that MedPAC should work towards I-SNP recommendations in its 2026-2027 cycle. He noted that current regulatory structures (extant for four decades) have resulted in no improvement in quality of care for I-SNP enrollees. He asserted that Medicare is trying to "hold the wrong entity accountable" (nursing homes, physicians), and instead should hold the I-SNP accountable. He articulated a two-part recommendation that would enable growth in I-SNPs, and do so in a way that aligns I-SNP care with the principles of good geriatric care. First, he asserted that Medicare should remove barriers to I-SNP formation, and second, to promote the growth of successful I-SNP plans that will improve quality of care.

Commissioner Konetzka echoed Commissioner Sarran's comments, particularly agreeing with the separation of the I-SNP model from the rest of MA. She touched on the tension between higher-paying Medicare-paid short skilled nursing facility stays, and longer-term lower-paying institutional stays. Commissioner Miller indicated that "heavy handed regulation of I-SNPs" hasn't improved quality of care. With respect to specific policy recommendations, Dr. Miller suggested that CMS be required to educate institutionalized beneficiaries about the availability of I-SNPs; he also seemed to endorse changes to I-SNP network adequacy, and a quality bonus program measure set specific to I-SNPs.

Vice Chair Rambur stated that she is very enthusiastic about the Commission engaging in this topic, and hopes that it continues in the next analytic cycle. Commissioner Upchurch also endorsed the Commission's continued work here.

8. PUBLIC COMMENT (IN-PERSON ATTENDEES ONLY) (12:15 PM - 12:30 PM)

The Commission provided an opportunity for in-person public comments for the first time since the COVID-19 pandemic. Shannon Wu, from the American Hospital Association made comments, suggesting that the Commission redouble its efforts to provide oversight of the Medicare Advantage program, noting in particular the burden on providers posed by MA utilization tools.